ACUTE INPATIENT

Definition

The *Montana Medicaid Mental Health Clinical Management Guidelines* (referred to hereafter as the *Clinical Management Guidelines)* define acute inpatient as services that are "provided 24 hours per day, 7 days a week, in an appropriately licensed facility by a multi-disciplinary team of licensed and appropriately credentialed professionals and professionally supervised paraprofessionals. Treatment is provided in a secure environment allowing for the most restrictive levels of care necessary for the well being and safety of the patient or others."

These services are provided to **Medicaid recipients only** in a psychiatric hospital or psychiatric unit to treat symptoms of such severity that the absence of immediate psychiatric intervention might lead to increased serious dysfunction, death, or harm to self or others.

Prior Authorization Reviews

All admissions to the acute inpatient facility require prior authorization and must meet medical necessity as defined in the *Clinical Management Guidelines*. Refer to page AIP-18 of this section for the *Clinical Management Guidelines* specific to Acute Inpatient services.

Continued Stay Reviews

Lengths of stay for in-state providers for acute inpatient services are diagnosis related group (DRG) based and do not require Continued Stay Review by First Health Services of Montana.

Acute inpatient services for out-of-state providers are reimbursed on a per diem basis and require Continued Stay Reviews. Continued stays require prior authorization and must meet medical necessity criteria as defined in the *Clinical Management Guidelines* for Acute Inpatient Services, beginning on page AIP-18 of this section.

Retrospective Reviews

Acute inpatient services are not subject to Retrospective Review by First Health Services of Montana unless otherwise requested by the Department of Public Health and Human Services.

Discharge Procedure

Upon recipient's discharge from any service for which prior authorization or continued stay reviews have been performed, the provider must complete a *Discharge Notification Form*. (See **FORMS** section of this manual.) This form must be submitted for First Health Services of Montana within five (5) business days after discharge. For in-state admissions, an admission

approval/PA number cannot be issued until First Health Services of Montana has received a completed *Discharge Notification Form*.

Prior Authorization Review Procedure

Admissions

Admission for acute inpatient services is an emergency admission as defined below. The federal guidelines applied to the prior authorization procedure for Acute Inpatient Services are specific to emergency admissions.

Definition

An emergency admission is a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medication attention could reasonably be expected to result in the serious dysfunction of any bodily organ/part, death of the recipient, or harm to another person by the individual.

Prior Authorization Review Procedure

A. Medicaid Beneficiary Age Under 21

Since inpatient psychiatric admissions often occur during non-business hours, it may not be possible to obtain authorization for these services prior to them being rendered. Therefore, the following procedure will be followed for inpatient admission reviews.

1. The provider must verify the beneficiary's Medicaid eligibility.

2. For all admissions the provider is responsible for notifying First Health Services of Montana by faxing a *Prior Authorization Request* form within 24 hours/one (1) business day of the admission. Delay in contacting First Health Services of Montana beyond 24 hours/one (1) business day will result in a technical denial or admission approval.

3. The provider must submit the *Prior Authorization Request* form by fax that includes demographic and clinical information at the time of the initial notification to First Health Services of Montana. This information must be sufficient for the clinical reviewer to make a determination regarding medical necessity and must include:
    - Demographic information
    - Recipient's Medicaid ID number (MID)
    - Recipient's Social Security Number (SSN)
    - Recipient's name, date of birth, county of eligibility, and sex

- Recipient's address, county of eligibility, telephone number
- Responsible party name, address, phone number
- Provider name, provider number, and date of admission

- Clinical Information
  - Prior inpatient treatment
  - Prior outpatient treatment/alternative treatment
  - Initial treatment plan
  - DSM-IV-TR diagnosis on Axis I through V
  - Medication history
  - Current symptoms requiring inpatient care
  - Chronic behavior/symptoms
  - Appropriate medical, social, and family histories

4. The recipient's treatment must be documented to meet all three (3) of the following criteria:

   1) Ambulatory resources in the community do not meet the treatment needs of the recipient (42CFR 441.152 [a][1]).

   2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician advisor (42CFR 441.152 [a][2]).

   3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed (42CFR 441.152 [a][3]).

5. Upon fax receipt of the above documentation, First Health Services of Montana's clinical reviewer will complete the review process as demonstrated in the *Prior Authorization Flow Chart* (Appendix A)

   - The authorization review will be completed within two (2) business days from receipt of the review request and clinical information providing the information submitted is sufficient for the clinical reviewer to make a determination regarding medical necessity.

- If the reviewer determines that additional information is needed to complete the review, the provider must submit the requested information within five (5) days of the request for additional information; and

- The authorization review will be completed within two (2) business days from receipt of additional information.

6. The provider must submit a completed and valid CON within 14 days of admission as required in ARM 37.88.1116 (3), 42 CFR 441-152, and 42 CFR 441-153. Providers are encouraged to submit the CON upon completion if it is completed prior to the allotted 14 days. See discussion regarding CON procedures for specific requirements (pages AIP 9-12 of this manual.)

7. If medical necessity is met **and** the CON has been completed within 14 days time period, then the First Health Services of Montana reviewer will continue the admission approval as follows:

   a) If CON signatures are within 14 days of the admission: Then First Health Services of Montana shall enter the "start date" for admission approval as the admission date **if**

      - The admission is otherwise approvable; **AND**

      - The provider contacted First Health Services of Montana within 24 hours/one (1) business day of admission.

   b) If the provider did not contact First Health Services of Montana within 24 hours/one (1) business day, then First Health Services of Montana shall technically deny.

   c) If either of the signatures if beyond 14 days from admission: Then the earliest "start date" for admission approval shall be the latest date the CON was signed by either team member, **if**

      - The provider contacted First Health Services of Montana within one (1) business day after admission; **AND**

      - The admission is otherwise approvable.

   Example:

Date of admission	March 3, 2003
Date provider notified First Health Services of Montana	March 4, 2003
First CON signature/date	March 13, 2003
Second CON signature/date	March 20, 2003
Earliest "start date" for admission approval if otherwise approvable	March 20, 2003

8. If medical necessity is not met, then the care is deferred to a Board-certified psychiatrist in the First Health National Clinical Review Center for review and determination.

Admission approval/PA number cannot be issued until First Health Services of Montana has received a valid CON and a completed *Discharge Notification Form.*

B. Medicaid Recipient Age 21 and over

Excluding any definitions or procedural steps relating to the CON, all other definitions and procedural steps apply**.**

CONTINUED STAY REVIEW PROCEDURE
OUT OF STATE PROVIDERS ONLY

Definition

A continued stay review is a review of currently delivered treatment to determine ongoing medical necessity for a continued level of care.

Reviews of requests for continued stay authorization are based on updated treatment plans, progress notes, and recommendations of the individual's treatment team. Continued stay requests require prior authorization and must meet the medical necessity criteria as defined in the *Clinical Management Guidelines*. (Refer to page AIP-18 of this section for the Acute Inpatient Services *Clinical Management Guidelines*).

Length of Stay

When services are performed by an out-of-state facility/provider, First Health Services of Montana will conduct continued stay reviews for all medically necessary stays for Acute Inpatient services that extend beyond the number of days initially authorized. Each continued stay review may permit authorization of additional treatment when medical necessity is determined. Subsequent continued stay reviews will occur until the recipient is discharged from the facility or medical necessity is no longer met.

Continued Stay Review Procedure

1. The provider is responsible for contacting First health Services of Montana by fax 24 hours/one (1) business day prior to the termination of the initial certification.

2. The provider must submit the following information to complete a continued stay review:

    - Continued Stay Authorization Request form (See FORMS section)
    - Changes to current DSM-IV-TR diagnosis on Axis I through V
    - Justification for continued services at this level of care
    - Behavioral Management Interventions/Critical Incidents
    - Assessment of treatment progress related to admitting symptoms and identified treatment goals

- Current list of medications or rationale for medication changes, if applicable

- Projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan

3. Upon fax receipt of the above documentation, First Health Services of Montana's clinical reviewer will complete the review process as demonstrated in the *Continued Stay Review Flow Chart* (Appendix B).

    - The continued stay review will be completed within two (2) business days from receipt of the review request and clinical information providing the information submitted is sufficient for the clinical reviewer to make a determination regarding medical necessity.

        - If the reviewer determines that additional information is needed to complete the review, the provider must submit the requested information within five (5) days of the request for additional information; and

        - The continued stay review will be completed within two (2) business days from receipt of additional information.

4. If medical necessity is met, the First Health Services of Montana reviewer will authorize the continued stay and generate notification to all appropriate parties.

5. If medical necessity is not met then the case is deferred to a Board-certified psychiatrist in the First Health National Clinical Review Center for review and determination.

Admission approval/PA number cannot be issued until First Health Services of Montana has received a valid CON and a completed Discharge Notification form.

Discharge Procedure

Upon recipient's discharge from any service for which prior authorization or continued stay reviews have been performed, the provider must complete a Discharge Notification form. This form must be submitted to First Health Services of Montana within five (5) business days after discharge.

CERTIFICATE OF NEED

Definition

A Certificate of Need (CON) is a state and Federal requirement (ARM 37.88.1116, 42 CFR 441.152 and 441.153) for documentation for inpatient hospitalization for Medicaid beneficiary under age 21 and over age 65. An interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in the facility develop the patient's plan of care and complete the CON. The CON certifies that:

1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;

2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

3) The services can reasonable be expected to improve the recipient's condition of prevent further regression so that the services will no longer be needed.

Admission CON Procedure

The certification must be performed within 14 days after admission as defined in 24 CFR 441.153. Provider are encouraged to submit the CON (see FORMS section) upon completion if it is completed prior to the allotted 14 days. The provider must maintain the original CON and provider a copy to First Health Services of Montana.

When a recipient has been determined to be Medicaid eligible by the department as of the time of admission to the facility the team completing the CON must include:

- A physician that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry;
- A licensed mental health profession; and
- Additional members as noted in 42 CFR 441.153 and 441.156 (below).

According to 42 CFR 441.153 the team certifying need for services under Sec. 441.152 of this CFR, must be made by terms specified as follows:

(a) For an individual who is a recipient when admitted to a facility or program, certification must be made by an independent team that:

(1) Includes a physician;

(2) Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and

(3) Has knowledge of the individual's situation.

Additionally, the treatment team responsible for the recipient's plan of care must complete, sign, and date the CON. As set forth in 42 CFR 441.156, this team must include as a minimum, either:

1) A Board-eligible or Board-certified psychiatrist; or

2) A clinical psychologist who has a doctoral degree and a physician license to practice medicine or osteopathy; or

3) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

The team must also include one of the following:

1) A psychiatric social worker.

2) A registered nurse with specialized training or one year's experience in treating mentally ill individuals.

3) An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals.

4) A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

During the prior authorization review, First Health Services of Montana will ensure that the physician signing the CON is eligible to do so per federal and state CON requirements. First Health Services of Montana will verify that the CON was received and complete before entry into the database. This review will include a determination as to whether the signatures of the interdisciplinary team members were individually dated within 14 days of the admission. Authorization is dependent upon not only meeting medical necessity, but also upon completion of the CON within 14 days of admission.

(***Please refer to the following table for clarification of required signatures.)***

NOTE: The ARM 37.88.1116 (c)(4) specifically states, "An authorization by the department of its utilization review under this rule is not final or conclusive determination of medical necessity and does not prevent the department or its agents from evaluating or determining the medical necessity of services or items at any time."

Summary of Required Signatures
A **minimum** of two signatures from the team members as described above, are required on the CON.
First, one of the signatures or group of signatures must be that of: • A psychiatrist; **OR** • A doctoral degree clinical psychologist **AND** a licensed physician; **OR** • A licensed physician with specialized training and experience in the diagnosis and treatment of mental diseases **AND** a psychologist who has a master's degree in clinical psychology or who has been certified by the Sate or by the State psychological association.
Second, one additional signature must be that of: • A psychiatric social worker; **OR** • A registered nurse with specialized training or one year's experience in treating mentally ill individuals; **OR** • An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals; **OR** • A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

Recipient Determined Eligible After Admission to or Discharge from the Facility

If Medicaid eligibility is unknown or is pending at the time of admission, the following CON guidelines established by the 42 CFR 441.153 Subpart D and ARM 37.88.1116 apply.

For an individual who applied for Medicaid while in the facility or program, the CON must be:

- Made by the team responsible for the plan or care as specified in 42 CFR 441.156; and
- Cover any period before application for which claims are made.

When a recipient has been determined Medicaid eligible by the department after admission to or discharge from the facility the CON must:

- Be completed, signed, and dated within:
  - 14 days after the eligibility determination for recipients determined eligible during the stay in the facility; or
  - 90 days after the eligibility determination for recipients determined eligible after discharge from the facility;

- Cover the recipient's stay from admission through the date of certification is completed; and

- Be made by the facility team responsible for the recipient's plan of care as specified in 42 CFR, 441.155 and 441.156.

DETERMINATIONS

Upon completion of the review, one of the following determinations will be applied and notification will be made as outlined in **Notification Process** of this section:

1) **Authorization**:

   An authorization determination indicates that utilization review resulted in approval of all provider requested services and /or service units and a prior authorization number is issued.

2) **Pending Authorization**:

   Indicates that a First Health Services of Montana reviewer or First Health psychiatrist has requested additional information from the provider. The provider will have five (5) days to provide any additional information needed to make a payment determination.

3) **Partial Approval**:

   Partial approval is considered an adverse payment determination indicating that the request does not meet the appropriate Medicaid criteria to justify Medicaid payments for the level or complete duration of services requested. Only a First Health psychiatrist may issue a partial approval. Partial approvals are subject to the First Health Services of Montana Appeal process.

4) **Denial**:

   The request for authorization of payment does not meet the appropriate Medicaid medical necessity criteria to justify Medicaid payment for the services requested. Authorization for payment is denied. Only a First Health psychiatrist may issue a denial. Denials are subject to the First Health Services of Montana Appeal process.

5) Technical Denial (Administrative Denial):

A prior authorization review was not administered on medical necessity criteria as a result of provider Medicaid protocol non-compliance. Non-compliance indicates that the request and/or information was out of specified timeframes or was incomplete. Technical denials may be appealed to the Addictive and Mental Disorders Division or the Children's Mental Health Bureau within 30 days of date of notification.

> ***NOTE:*** The ARM specifically states, "An authorization by the department of its utilization review under this rule is not final or conclusive determination of medical necessity and does not prevent the department or its agents from evaluating or determining the medical necessity of services or items at any time."

NOTIFICATION PROCESS

First Health Services of Montana recognizes the importance of prompt notification to all relevant parties with regard to authorizations and denials. "Relevant parties" is defined as beneficiaries, families or guardians of beneficiaries, requesting providers, and the Department. When appropriate, First Health Services of Montana will notify the Regional Care Coordinator to assist in the transition to other levels of care.

First health Services of Montana will implement a two-step notification process, providing both informal and formal notification.

Informal Notification

Informal notification will be completed via facsimile on a daily basis and will include an:

- **Outcome report to the department of all determinations, regardless of region or provider**
- Outcome report of all determinations will be given to each provider (provider specific information only)
- Outcome report of all determinations will be provided to the Regional Care Coordinator (region specific only).

The above outcome reports are generated and transmitted via facsimile by 9:00 AM Mountain Time on the next business day.

Formal Notification

Formal notification will be made providing all relevant parties with a hardcopy determination sent by US Mail.

- Authorization determinations will be mailed by regular US mail
- Denial determinations (technical denial or denial for medically unnecessary) will be mailed certified, return receipt mail and tracked to ensure delivery.
    - Notifications for technical denials will include:
        - Dates of service that are denied a payment recommendation because of non-compliance with Administrative Rule

- Reference applicable to federal and/or state regulations
- An explanation of the right of the parties to request an Appeal
- Name and address of person to contact to request an Appeal
- A brief statement of the First Health Services of Montana's contractual responsibility to the State of Montana for utilization reviews

- Notifications for denial determinations for medically unnecessarily treatment/services will include:
  - Dates of service that are denied a payment recommendation because the services in question are considered medically unnecessary according to Medicaid criteria or protocols
  - Case specific denial rationale based on the medical necessity criteria upon which the determination was made
  - Reference federal and/or state regulations governing the review process
  - Date of notice of First Health Services of Montana's decision which is the date of printing and mailing; and/or the date of the confirmed facsimile transmission
  - An explanation of the right of the recipient (or legal guardian), the psychiatrist/physician, and/or the provider to request an Appeal
  - Name and address of person of office to contract to request an Appeal
  - A brief statement of First Health Services of Montana's contractual responsibility to the State of Montana for utilization reviews

FIRST HEALTH SERVICES OF MONTANA
APPEAL PROCESS

Definition

Appeal—Consumer, provider, or agent's challenge of a denial. Appeal may be indicated through the use of any one of the following terms: Appeal, Administrative Review, Reconsideration, or Fair Hearing.

Process

All adverse determinations are made by Board-certified psychiatrists. The First Health Services of Montana review process is designed to take advantage of the Montana-specific knowledge of treatment availability, access, and program strengths that the Montana physician panel brings to the determination process. Therefore, First Health Services of Montana will defer appeals to a Montana-based physician for final determination whenever possible. First Health's panel includes a sufficient number of psychiatrists certified by the American Board of Psychiatry and Neurology so that all appeal determinations will be completed by a psychiatrist not involved in the original adverse determination. This process allows for a choice of a peer-to-0peer or a desk-based review using the following process:

a. Upon receipt of an adverse determination, the recipient or recipient's guardian or the provider/facility may request an appeal of the adverse determination.

b. The request for appeal must be received at the First Health Services of Montana, Helena office within 30 day of the date of receipt of the determination notice.

c. The request for appeal must specify the option of peer discussion/review or desk review. Any additional information to be considered must be included with the request.

Peer-to-Peer Discussion/Review:
Scheduling of peer reviews must be requested and coordinated through the First Health Services of Montana, Helena office. To permit completion of the appeal process within five (5) business days of receipt of the request, the peer-to-peer discussion will be requested and must be completed within 72 hours/three (3) business days of receipt of the request.

Desk Review:
A desk review will be performed whenever a peer review has not been requested or when the request for appeal does not specify peer discussion or desk review.

d. First Health Services of Montana completes the appeal review within five (5) business days of the receipt of the request. A Board-certified psychiatrist, who has no prior knowledge of the case of professional relationship or ties with the provider, completes the reconsideration review. Whenever possible, Montana licensed and based Board-certified psychiatrists will complete these reviews.
e. All final determinations include rational for the determination based upon the applicable federal and state regulations, and include instructions as to the rights of further appeal.
f. The determination rendered by the appellate physician performing the review will, in all cases, stand as the final First Health Services of Montana decision.
g. If the appeal review upholds by the adverse determination, the rights of the provider and/or beneficiary to an administrative review or reconsideration with the Montana Department of Public Health and Human Services will be included in the formal notification. First Health Board-certified psychiatrists may provide input regarding the determination rationale, application of federal and state regulations, and other relevant information.

Please refer to Appendix C for the *First Health Services of Montana Appeal Process* Flow Chart.

Notification Process—Appeal Determinations

In accordance with state and federal policy, First Health Services of Montana will provider written notification of the appeal determination to the recipient or recipient's legal guardian and the provider/facility of their right to the next level of appeal. Notification will include those elements as discussed in the **"Notification Process"** of this section.

Fair Hearing Process

First Health will be available to participate in the Medicaid Fair Hearing process to provide testimony related to the determination under appeal and will provide copies of all documentation and correspondence related to the determination under appeal.

Please refer to the notification letter for detailed instructions regarding Appeals/Reconsiderations/Administrative Review/Fair Hearing processes.

ACUTE INPATIENT
CLINICAL MANAGEMENT GUIDELINES

First Health Services of Montana will employ the use of the *Montana Medicaid Clinical Management Guidelines* strictly as guidelines. This practical application, couple with our professional judgment based on clinical expertise and National best practices, will enhance the rendering of authorization decisions for both the adult and under 21 years of age populations.

The *Clinical Management Guidelines* for Acute Inpatient, including admission, continued stay, and discharge criteria are as follows:

Inpatient services are provided 24 hours per day, 7 days a week, in an appropriately licensed facility by a multi-disciplinary team of licensed and appropriately credentialed professionals and professionally supervised paraprofessionals. Treatment is provided in a secure environment allowing for the most restrictive levels of care necessary for the well being and safety of the patient or others. Staff must include, but not be limited to, board eligible or certified psychiatrists, registered nurses, other licensed mental health professionals and other ancillary staff.

Patients are seen and evaluated by a physician who documents, consistent with the standards of JCAHO and/or licensing agencies, within 24 hours, the patient's clinical history, the results of the professional's examination. The treatment plan must include individual and/or group psychotherapy, with involvement of the multi-disciplinary team, appropriate family members, and all active pre-hospital admission caregivers. The course of treatment and the patient's response to treatment efforts must be thoroughly documented in records consistent with the standards of JCAHO and/or licensing agencies, with daily assessments reflecting progress toward discharge of the patient to a lower level of intensity of care. Records should reflect the initiation of discharge planning at the time of admission.

Admission Criteria

1. A DSM-IV diagnosis, that is covered under the provisions of Montana Medicaid, as the principal diagnosis, and at least one of the following:

2. Dangerous to self as exhibited by ideas or behaviors resulting from the DSM-IV diagnosis, as evidenced by behaviors which may include, but not be limited to,

    a) an attempt or threat to harm self with continued acuity of risk, which cannot be safely or appropriately treated or contained in a less restrictive level of care.

    b) An inability for the patient to contract for safety.

    c) A specific plan for harming self and some acute risk of carrying out this plan.

d) Self-destructive impulses accompanied by rejection of, or lack of, available social/therapeutic support.

e) Actions, or threats of actions, which could predictably result in harm to self, with the patient lacking either the insight or impulse control to refrain from such behaviors.

f) A past history of actions harmful to self and clear clinical evidence that high risk exists presently for a recurrence of such behavior.

3. Dangerousness to others, as exhibited by ideas or behaviors resulting from the DSM-IV diagnosis, as evidenced by behaviors which may include, but not be limited to,

a) Actions, or threats of actions, intended to harm others.

b) Actions, or threats of actions, which could predictably result in harm to others, with the patient lacking either the insight or impulse control to refrain from such behaviors.

c) A specific plan to harm others with the intention of carrying out this plan.

d) Current threats to harm others without the ability to contract for the other person's safety.

e) A past history of actions harmful to others and clear clinical evidence that high risk exists presently for a recurrence of such behavior.

4. Grave disability, as exhibited by ideas or behaviors resulting from the DSM-IV diagnosis, as evidenced by behaviors which may include, but not be limited to,

a) Mental status deterioration sufficient to render the patient unable to reasonably provide for their own safety and well-being.

b) An acute exacerbation of symptoms sufficient to render the patient unable to reasonably provide for their own safety and well-being.

c) Deterioration in the patient's function in the community sufficient to render the patient unable to reasonably provide for their own safety and well-being.

d) An inability or refusal of the patient to cooperate with treatment combined with symptoms or behaviors sufficient to render the patient unable to reasonably provide for their own safety and well-being.

e) A clinician's inability to adequately assess and diagnose a patient, as a result of the patient's non-compliance or as a result of the unusually complicated nature of a patient's clinical presentation, with behaviors or symptoms sufficient to render the patient unable to reasonably provide for their own safety and well-being.

Continued Treatment Criteria

1. DSM-IV diagnosis, that is covered under the provisions of Montana Medicaid, as the principal diagnosis.

AND

2. Active treatment is occurring which is focused on stabilizing or reversing symptoms which meet the admission criteria and which still exist.

AND

3. A lower level of care is inadequate to meet the patient's needs with regard to either treatment or safety.

AND

4. There is reasonable likelihood of clinically significant benefit as a result of medical intervention requiring the inpatient setting.

OR

5. A high likelihood of either risk to the patient's safety or clinical well-being or of further significant acute deterioration in the patient's condition without continued care in the inpatient setting, with lower levels of care inadequate to meet these needs.

OR

6. Appearance of new impairments meeting admission guidelines.

Discharge Criteria

1. The symptoms/behaviors that required services at this level of care have improved sufficiently to permit treatment at a lower level of care.

AND

2. A comprehensive discharge plan has been developed and is ready to be implemented.

OR

3. The patient voluntarily withdraws from treatment and does not meet criteria for involuntary treatment.